Livingston PUBLIC SCHOOLS

11 Foxcroft Drive
Livingston, NJ 07039

Phone: 973-535-8000
FAX: 973-535-1254

Student Medical Certificate

Student Name: _____ Grade/Homeroom: _____

I. To Be Completed By Parent / Adult Student:

I, _____ , hereby authorize this physician to provide the following information to Livingston Public Schools relating to absence from school.

_____ _____
Signature Date

II. To Be Completed By Physician:

I hereby certify that I provided health care services to _____ , a student in the Livingston Public Schools on the following date(s): _____

On the basis of that episode of care, I am providing the following information for use by the district in determining if this absence should be excused.

1. Diagnosis and Time Line of the Problem:
   a) Diagnosis: _____
   b) Date of onset of problem (or most recent episode if problem is chronic): _____
   c) Expected duration of the problem or most recent episode: _____
2. Is this an acute or chronic problem for the student? ☐ Yes ☐ No
3. The student's symptoms were subjective, with limited findings: ☐ Yes ☐ No
4. Student seen when ill? ☐ Yes ☐ No

VERIFICATION BY PHYSICIAN:

Name (please print): _____

Address: _____
(stamp, business card or letterhead acceptable)

Phone Number: _____ Registration No. CPSO: _____

_____ _____
Signature Date